AlaskaCare℠
HEALTH PLANS

Active Employee / Dependents – Group #721059
Medical / Audio and Non-Participating Prescription Benefits Claim Form

☐ **Please check if you are submitting for copay because you have a secondary plan.**

Use this form for submitting Medical / Audio and Non-Participating Prescription claims from Doctors, Clinics, Labs, etc. Special forms are available for Vision, Prescription Drug, or Dental claims. Contact your employer or Aetna U.S. Healthcare of Washington for additional forms. COMPLETE FORM—SIGN BELOW—ATTACH ITEMIZED BILL—MAIL TO ADDRESS ON THIS FORM.

Complete this form and submit to:
Aetna U.S. Healthcare of Washington
P.O. Box 91028
Seattle, WA 98111-9128
1-888-252-2734

Part 1 / Patient Information – Use separate form for each patient

1 Patient's Name
First Initial Last

2 Birthdate
Mo Day Year

3 Relation to Participant ☐ Self ☐ Spouse ☐ Child ☐ Step Child ☐ Other

If claim is for dependent child, when charges were incurred, was child:
Married? ☐ Yes ☐ No Employed? ☐ Yes ☐ No
Unable to work due to disability? ☐ Yes ☐ No
Covered by accident insurance through school? ☐ Yes ☐ No
Give name and address of current or former employer or school:

_____

4 Patient ☐ M ☐ F

5 Participant's Social Security No. ___ – ___ – ____

6 Participant's Name, Address, City, State, Zip

_____

_____

_____

Is this a New Address? ☐ Yes ☐ No

7 Participant's Telephone No. (_____) _____

8 Is this claim for an annual well-physical examination? ☐ Yes ☐ No

9 Is this claim due to an accident or injury? ☐ Yes ☐ No
☐ Home ☐ Auto ☐ School ☐ Work

☐ Other_____

Date of Accident_____ Time of Accident_____ ☐ AM ☐ PM

If another party was responsible for the accident, do you intend to make a claim against this party? ☐ Yes ☐ No

9A If accident occured at work is case covered under Workers' Compensation? ☐ Yes ☐ No

10 Do you or any of your dependents have other group medical coverage? ☐ Yes ☐ No
(This includes other Aetna U.S. Healthcare of Washington coverage)

Name and Address of other Carrier_____

_____

Name of Covered Person(s)_____

Account (ID) Number _____

Group Number (if any) _____

Coverage is for: ☐ Patient ☐ Spouse ☐ Children

Part 2 / Medical Information – Use separate form for each provider (Dr., clinic, lab., etc.)

11 Provider's (Dr., Clinic, Lab., etc.) Name and Address

_____

_____

_____

Provider's Telephone No. (_____) _____

12 Provider's IRS Tax Number or Doctor's Social Security No.
You are required by law to provide this number.

13 Have these charges been paid?
☐ Yes ☐ No (If No, payment will be made to the provider.)

14 Is this illness ☐ New ☐ Continued
Date of Onset _____

15 Type of Operation? (If unusual or complicated, attach operative report.)

16 Date(s) of Service(s)	RVS or CPT Code	Itemized Description of Services	Diagnosis (including complications or ICDA Code)	Charge for Each Service
			TOTAL	17 0.00

Any person who knowingly and with intent to defraud or deceive any insurance company files a statement of claim containing any materially false, incomplete or misleading information is guilty of a crime.

TO ALL PROVIDERS OF HEALTH SERVICES: You are authorized to provide consulting health professionals acting on Aetna U.S. Healthcare's behalf with the information needed to evaluate and administer claims for benefits. I know that I have a right to receive a copy of this authorization upon request and agree that a photographic copy of this authorization is as valid as the original.

Date: _____ **Patient's or Authorized Person's Signature** _____